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ABSTRACT

The paper addresses the issue as to whether large scale programs of primary prevention are feasible for children with emotional disorders. The problem of translating common definitions of primary prevention into viable programs is considered. A typology of three major approaches to primary prevention is presented: (1) programs promoting and enhancing competency (which include parents' early involvement in children's learning); (2) primary prevention through environmental and systems change; and (3) reducing disorder by identifying populations at risk. Specific recommendations are suggested for hastening the advance of primary prevention programs including that programs include preparation for parenting of all adolescents in normal school settings and that families and children be considered as a unit. (SBH)

PRIMARY PREVENTION OF EMOTIONAL DISORDERS OF CHILDREN: MIRAGE OR REALITY

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PRIMARY PREVENTION OF EMOTIONAL DISORDERS OF CHILDREN: MIRAGE OR REALITY*

Early in 1978 the Report of the President's Commission on Mental Health highlighted the need to provide services for underserved vulnerable populations. Specifically, the Commission selected children as a major target group for primary prevention efforts. Highest priority was accorded to programming for children from the prenatal period to adolescence. These recommendations strike a responsive chord for all who work with children. Preventive work with children has been a major emphasis of the pioneers in community mental health (Caplan, 1964). The major issue, however, which faces the Commission and the field as a whole is that of implementation of the recommendations through programs that are truly "preventive".

Advancement of true primary prevention programs specifically designed for children must await the conquest of at least two major obstacles: (1) definitional problems and (2) translation of common definitions into viable programs. This paper will address these issues drawing on research and theory. Finally, recommendations leading to increased implementation of programs of primary prevention will be made.

What is Primary Prevention: The Definitional Problem

To most of us "primary prevention" and programs of "primary prevention of emotional disorder" of children appear to be as unambiguously wholesome as apple pie. Unfortunately, that kind of analogy is reminiscent of the 50's and early 60's where theories of

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primary prevention in mental health first began to flourish (Caplan, 1964). Now in the 70's the beliefs of the past two decades are being challenged.

Approaches of the recent past in the field of mental health are criticized as being based on unproven assumptions and thus using energy and resources that should be allocated to more well established needs and programs. Translated into specific criticisms of primary prevention we find those who question primary prevention as a necessary component of community mental health (Sanford, 1972) or, more seriously, as diverting resources from the identified mentally ill (Zusman, 1977). Additionally, as Bloom (1968) and Munoz (1976) indicate, there is only the beginning of hard evidence that primary prevention programs have positive results. Evaluations of prevention programs still are in their infancy.

Clearly among the most serious of the questions raised about the definition of primary prevention are those posed by its advocates (Reinherz, 1979). In spite of controversy and confusion there are some general areas of agreement allowing for a general conceptual consensus.

First of all there is general agreement that the concept originated in the field of public health. Thus, in the public health model, "primary prevention" refers to activities undertaken prior to the onset of disease with the goal of avoiding its occurrence and building resistance in a potentially vulnerable population, the "population at risk" (Leavell and Clark, 1965). An example of primary prevention is the innoculation of <u>all</u> children for diptheria and small pox. Furthermore,

primary prevention also includes the promotion of positive health through promoting healthful life styles.

Secondary prevention in public health consists of early diagnosis and treatment for those at the early stages of illness. Screening programs for early identification of a variety of problems such as high blood pressure are included under this rubric. Rehabilitative programs aimed at reducing the after effects of illness constitute programs of tertiary prevention.

In general the early advocates of community mental health translated the public health model directly into the mental health field (Caplan, 1974).

> Primary prevention aims at reducing the incidence of new cases of mental disorder in the population by combatting harmful forces which operate in the community and by strengthening the capacity of people to withstand stress.
>
> Secondary prevention aims at reducing the duration of cases of mental disorder which occur in spite of the programs of primary prevention. By shortening the duration of existing cases, the prevalence of mental disorder in the community is reduced...
>
> Tertiary prevention aims at reducing the community rate of residual defect which is a sequel to mental disorder. It seeks to ensure that people who have recovered from mental disorder will be hampered as little as possible by their past difficulties in returning to full participation in the occupational and social life of the community. (Caplan, 1974, pp. 189-190.)

Cowen (1977) and Goldston (1977) have further narrowed the definition by declaring that only primary prevention programs be called "prevention". Both of these authors believe that targets of intervention must be populations not individuals. Goldston (1977) also believes that programs of primary prevention must be addressed to "specific populations for specific purposes." Using the rigorous

and more stringent rules we will evaluate several programs specially directed to children that are currently cited as examples of primary prevention.

Translating Definition into Action: Primary Prevention Programs for Children

Three major program typologies will be presented. The first two meet the most stringent of the criteria set forth. The third model can be placed on the boundary between primary and secondary prevention. (A rationale will be presented for its inclusion.)

Programs Promoting and Enhancing Competency

All definitions of primary prevention clearly include the concept of defending against the emergence of mental health problems by building strength and coping capacity. In the case of children the target population includes parents (families) who must also be involved in appropriate intervention (Murphy and Chandler, 1972; Berlin, 1975).

The report of the President's Commission (1978) highlights pregnancy and the perinatal period as a time for providing total health care both for mother and developing infant. Research furnishes evidence that new mothers who were prepared for childbirth experienced more positive reactions to the birth and the infant than mothers who were not prepared (Doering and Entwisle, 1975). The early perinatal period, also, is a time for building parenting skills (Berlin, 1975). My own research over the past decade, in which children with major adjustment problems were only identified after problems had escalated and were entrenched, underscores this need (Reinherz and Griffin, 1971).

Parents' early involvement in children's learning can enhance a child's competence and provide support for later school adjustment so

crucial to a child's present and future functioning (Berlin, 1975; Reinherz and Griffin, 1971). Toddlers' preschools have been initiated in some target neighborhoods providing group experiences for children as well as participation by parents.

In a report of a project in the St. Louis area (Glidewell, Gildea, Kaufman, 1973) concluded that parents involved in mental health discussion groups reported significantly fewer behavioral problems over a 30-month period than parents not receiving such services. Social adjustment skills can be taught to children and mastery of problem-solving techniques have been found to be beneficial in later adaptation of children (Shure et al., 1972). Reports of programs to aid parents in promoting healthy emotional development of their children are increasingly appearing in professional journals (D'Augelli and Weener, 1978). The importance of including the total family is underscored in the writings of Bronfenbrenner (1974) and Mitchell and Scherman (1977) who identify the family as the most effective and economical system for fostering and sustaining a child's psychological development.

Extensive technology already exists and has been developed and utilized for promoting positive growth and development of children through the use of role-modeling and training in an educative role for parents of young children. Berlin (1975) describes those techniques for affective development and Spivack and Shure (1977) for cognitive as well as general competency growth.

The above review of preventive programs speaking directly to enhancing competency has both optimistic and pessimistic aspects. On the positive side, the requisite techniques including mental health

education and provision of role models for parenting already exist. Secondly, it is hopeful that many of these programs are reported in the literature. Third, a small number have been positively evaluated at least for a relatively short term outcome (D'Augelli and Weener, 1978; Spivack and Shure, 1977; Glidewell et al., 1973).

On the negative side is the fact that the ideas and techniques of enhancing and promoting competency were first conceived in the 50's (Glidewell et al., 1973). They still have not had widespread acceptance and/or adoption indicating that implementation is far behind the original conception. Next we will turn to an even more ambitious type of programming for primary prevention.

Primary Prevention through Environmental and Systems Change

Cowen (1977) considers systems change one of the most challenging aspects of preventive programming for the mental health profession. If we consider the plight of children who are one of the most vulnerable groups in relation to the institutions of society we can clearly see the relevance of such an approach. At the same time the kind of action-oriented program planning and intervention this approach requires makes enormous demands on the coping skills of mental health workers. To effect systems change mental health professionals must collaborate with many others including the administrators of large systems, the political policy makers and other professions including educators, architects, and lawyers.

After several years of research in a school system (Griffin and Reinherz, 1969), I and my colleagues presented findings of harmful effects to children of non-promotion policies which later resulted

in structural change in a school system. The changes called for early decision-making concerning children's capacity to cope with formal learning and flexible arrangements for groups of children and individuals. Knowing, as we now do, the negative effects of academic failure such policies can make significant differences in school adjustment and subsequent achievement and self-concept of children.

Through administrative consultation (Nir, 1973) to schools and social agencies mental health professionals may truly make significant differences in the lives of children. Since cognitive and personal development are clearly linked (Cowen, 1973), efforts to make school environments more conducive to total development should be further pursued. Sophisticated research efforts are called for in which specific environmental variables and individual temperamental characteristics are examined (Insel and Moos, 1974).

Under the rubric of creating systems change in the interpersonal sense, I would place the recent developments in creating natural support systems and natural networks on behalf of children (Collins, 1973; Caplan, 1974). With collaboration of "natural neighbors" mental health workers can promote helpful changes in the life spaces of children.

It is in the area of environmental systems change that at the present time the least is known and the need on behalf of children is greatest. Advocacy must clearly proceed; but it must be based on well-documented professional knowledge.

Reducing Disorder by Identifying Populations At Risk

The next group of programs are those that can be placed on the border of primary and secondary prevention. Such programs involve early identification of especially vulnerable children and families.

Many also incorporate intervention programs for those who move from a vulnerable pre-clinician state to an actual emotional disorder.

Programs in this model include several directed towards adolescent mothers and fathers (Singer, 1971 and Smith et al., 1971). Programs also have been created to provide group supports and opportunities for ventilation for families exposed to major disasters including floods and earthquakes (Blaufarb and Levine, 1972). Specifically focused programs to provide information and support have been provided for parents and siblings in families experiencing loss due to Sudden Infant Death Syndrome (Davis, 1975).

Each of the programs above is aimed at primary prevention of mental health breakdown in a specific group. They can be differentiated from the earlier models described in that they are more specifically focused on groups who have undergone stress producing experiences for the child and his family which may result in a negative mental health outcome. Clearly we are still within the broad boundaries of primary prevention.

The next area for discussion moves further into the area of secondary prevention. Here we encounter programs that identify prodromal signs of disorder whether it be emotional (Broussard, 1977) or of possible child abuse (Ayoub and Pfeifer, 1977; Kempe, 1976). Here the incipient disorder is suspected but is not manifested as yet. The last two examples clearly illustrate the process of "screening" suspected cases and then providing a strategy of intervention for preventing negative outcomes.

As we move into the screening area we begin to cross the boundary from primary to secondary prevention. The area of screening is a

controversial topic in itself since inaccurate results may lead to faulty labelling and stigmatization (Thorpe and Werner, 1974; Children's Defense Fund, 1977). However, in spite of criticism, screening appears to be increasingly encouraged nationwide (PL 94-142). Screening specifically for emotional problems moves us into the area of early case-finding and therefore secondary prevention. This is a worthy goal in itself. For, the remediation of identified emotional disorders of children has enormous implication in preventing later costs to the individual child and society at large. None of us would argue with the concept of detection and prompt, appropriate intervention. Yet, how do screening programs aimed at detecting a variety of "handicaps" fit under the primary prevention rubric?

Since 1975 I and my colleagues have been involved in creating and field testing a battery to detect a variety of development problems in children entering school*. The domains covered in the battery include health, familial background, development, cognition, sensory functioning, and behavior (Reinherz and Griffin, 1977). Although major effort has been placed on development of the behavioral scale which has the goal of identifying current behavior problems, the premise of the project is based on the philosophy expressed by Murphy and Chandler (1972) and Escalona (1974). These authors speak to the mental health (psychiatric) risk for the child inherent in dysfunctioning in <u>any</u> domain and the need for mastery of the tasks of each specific period in order to adequately cope with the challenges of the later stages of development.

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Thus, although screening for current behavior or emotional disorders clearly belongs in the domain of secondary prevention, remedial programs for identified lags and problems in sensory functioning, learning and health can clearly prevent mental distress in later childhood. A child with an undetected hearing problem, or a specific perceptual disability is likely to be at greater emotional risk than his peers. Therefore, programs created to identify and remedy existing developmental problems in all areas can serve a primary function in prevention of later mental health problems in children served by such programs.

Summary and Discussion

This presentation has emphasized the need for a common definition of prevention. The concept is most stringently defined as an activity which should be addressed to "population not individuals" (Cowen, 1977) and to "specific population for specific purposes". Three major types of existing primary prevention programs were described with a number of examples presented. The first two typologies, promoting and enhancing competency and creating environmental and systems change, fall clearly into the definition above. The third type, the most controversial, "reducing disorders by identifying populations at risk", is included with a specification of its role in primary prevention.

Some of the slowness of new program development can be attributed to both definitional obstacles and the difficult translation of abstract concepts into programs. However, there are a number of specific recommendations suggested to hasten the advance of primary prevention programs.

Recommendations

There is a clear need for mental health agencies to commit themselves over the long term to activities of primary prevention for children. With the exception of a few programs, such as those described by Kellam et al. (1975) and Glidewell et al. (1973), most appear to have a short life span and are not replicated. Since the intent of primary prevention programs is geared towards long term impact and since longitudinal evaluations are required, longevity is an important requirement.

Second, programs for children are needed at all age levels. The spectrum should include preparation for parenting for all adolescents in normal school settings. We must initiate programs of parent education from pregnancy through the child's adolescence. Initiating preventive programs for parents of children at the beginning of school entrance should be only one aspect of a total sequence of services.

Third, families and children must be considered as a unit. The most economical and efficient way to work with children is through the family (Mitchell and Scherman, 1977).

Fourth, efforts at enhancing mental health should go hand in hand with efforts at enhancing all aspects of the child's functioning particularly physical health (Stringer, 1978). This approach places emphasis on early work with expectant mothers and infants who may be reached through prenatal and well-baby clinics.

Fifth and last - a large share of resources will need to be allocated for programs of primary prevention. Current policies of deriving income from third party payments do not meet the need.

In total, it appears that there is a general consensus as to the scope of programs of primary prevention for children and indication that some of the technology already exists. All that remains to transform mirage to reality is a firm commitment by professionals and funding sources to enable this essential component of comprehensive mental health services to be truly implemented and truly tested.

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